Civicare Midlands Ltd

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Inspection report

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Date of inspection visit:
15 November 2016
16 November 2016
17 November 2016

Date of publication:
15 May 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 15, 16 and 17 November 2016 and was announced. At the last inspection completed 19 May 2016 the provider was not meeting a number of the regulations we inspected. The provider was not submitting notifications to CQC about significant events such as injury as required by law. The provider was also not meeting the regulations regarding providing person-centred care, safe care, responding to complaints, ensuring care staff were safely recruited for their roles and effective management of the service. At the inspection completed in November 2016 we found the provider had made improvements and was now meeting the regulations around providing safe and person-centred care. They had however failed to make sufficient improvements overall to improve the service and remained in breach of multiple regulations.

Civicare Midlands Ltd is a domiciliary care agency that is registered to provide personal care. At the time of the inspection the service was providing support to 42 people living in their own homes. Most of these were older people or people with a disability. There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from potential abuse as the provider did not ensure both they, the staff and management team were managing safeguarding concerns safely. People were not protected from harm due to unsafe recruitment practices. People were supported by sufficient numbers of staff and we found improvements had been made to the times at which people received their care visits. People were happy with the support they received with their medicines. However, some improvements were still needed in the safe management of medicines.

People's rights were not always upheld by the effective application of the Mental Capacity Act 2005. People told us the skills of the staff team had improved, however, we identified further areas of improvement were needed. People were happy with the support they received with their food and drink and most people's day to day health was maintained.

People told us care staff were mostly kind and caring however this was not always consistent across the whole staff team. People were supported to make choices about their care. However care staff did not always understand how to make choices in people's best interests where they lacked capacity to make these decisions. People were cared for in a dignified way and their independence was promoted.

Most people told us they received care that met their needs and preferences. The provider had not always identified where some people still did not receive care that met their needs. People told us the provider's response to complaints had improved but further improvement was still required.

People were cared for by a staff team who felt supported by the management team. However, people were not protected by a quality assurance system that identified the areas of improvement needed within the service. We found significant failings in the provider's ability to understand and recognise when care provided did not meet the required standards. The provider did not have an understanding of their legal requirements or the expected standards of providing consistently good, safe care to everyone using the service.

We found the provider was not meeting the regulations around safeguarding people from abuse, safe recruitment of care staff, consent to care, managing complaints, effective management of the service and submitted statutory notifications to CQC. You can see what action we told the provider to take at the back of the full version of the report.

At the last inspection completed in May 2016, we rated the provider as 'inadequate' and the service was placed into special measures. The overall rating for this service at this inspection is 'Inadequate' and the service therefore will remain in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from potential abuse. People were not protected from harm due to unsafe recruitment practices.

People were supported by sufficient numbers of staff. People were happy with the support they received with their medicines. Improvements were still needed in safe medicines management.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always upheld by the effective application of the Mental Capacity Act 2005. People told us the skills of the staff team had improved, however, we identified further areas of improvement were needed.

People were happy with the support they received with their food and drink and most people's day to day health was maintained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us care staff were mostly kind and caring however this was not always consistent across the whole staff team. Care staff did not always understand how to make choices in people's best interests where they lacked capacity to make these decisions.

People were cared for in a dignified way and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People told us the provider's response to complaints had

improved but further improvement was still required. Most people received care that met their needs and preferences however this was not always consistent for everyone using the service.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected by a quality assurance system that identified the areas of improvement needed within the service. The provider failed to recognise when areas of service and care provided did not meet the required standards. The provider did not understand their legal responsibilities.

People were cared for by a staff team who felt supported by the management team.

Civicare Midlands Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15, 16 and 17 November 2016 and was announced. We gave the provider 48 hours' notice of the inspection because it is a domiciliary care agency and we needed to be sure that the registered manager and staff would be available to speak to. The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

As part of the inspection we spoke with 11 people who used the service and eleven relatives. We met with two of these people and one relative in their own home to discuss the care they received from the service. We spoke with the provider who also held the role of the registered manager. We spoke with the deputy manager and five members of staff including the care supervisors, the care coordinator and care staff. We also spoke with one social care professional. We reviewed six people's care records including their medicine administration records, nine staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At the last inspection completed in May 2016 we rated the provider as 'inadequate' for the key question of 'is the service safe?'. We also identified they were not meeting the regulations regarding the provision of safe care and ensuring staff members were recruited safely. At this inspection we found the provider had met the regulation around providing safe care. However, we identified more serious concerns around the safe recruitment of staff members and also around protecting people using the service from potential abuse. The provider was not meeting these regulations.

People told us they felt safe with their care staff. One person told us, "I feel comfortable and safe with [the care staff]". People told us they knew who they could speak with if they were worried about something. A person told us, "I have family to talk to but if I have any problems I ring the office". Care staff we spoke with were able to describe signs of potential abuse and how they would report these concerns. However we found some care staff had been told by a person they may be experiencing abuse. The care staff had failed to report these concerns to managers. When the provider was made aware of the concerns they failed to report them to the police or the local safeguarding authority.The provider did not follow their own safeguarding policy and procedure and conducted their own internal investigation. The provider's actions potentially exposed the person to further harm. We spoke to the provider and the care supervisor involved in this incident. Neither understood the correct procedures for reporting potential abuse and protecting a person from the risk of further harm. We found the management within the service did not have a sufficient knowledge of how to report safeguarding concerns to ensure people could be sufficiently protected from potential abuse.

We identified a further incident where an existing staff member's conduct had proven to be inappropriate and may put people using the service at risk of potential abuse. The provider failed to recognise this staff member's conduct presented a potential risk to people. As a result appropriate action had not been taken to ensure people were protected from the risk of mistreatment. We identified several staff members with disclosures about their criminal history. The provider told us they had taken action to reduce this risk. For example they told us they ensured the staff member's always worked with another member of staff. However, we found that often two members of staff who were identified as a potential risk had been working together on care visits. These care staff were not always working with staff member's who were considered safe to work unsupervised. The provider demonstrated a lack of understanding around how to protect people from potential harm.

This was a breach of Regulation 13 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

We looked at how the provider ensured staff members were recruited safely and were appropriate to work in their role. We found the provider was completing interviews and pre-employment checks however these checks did not always ensure staff members were safe to work with people using the service. Staff member's employment histories were not always checked and queries raised where required. Many references obtained by the provider did not adequately demonstrate staff member's fitness to work. We found

references for several staff members had been obtained from 'personal referees', for example family friends or neighbours. The provider's recruitment policy stated that references should be sought from the staff members current / most recent employer. The policy outlines steps that should be taken to check the identity of the referee, for example, obtaining company letterhead or telephoning organisations. We found some references had been obtained from referees whose identity had not been checked. The provider had not taken any of these steps to ensure references provided were suitable and demonstrated the staff member's suitability to work with people.

We identified further concerns about the provider's recruitment processes. Disclosure and Barring Checks (DBS) were not always completed prior to staff members starting work. A DBS check enables the provider to view a staff member's potential criminal history. Where DBS checks highlighted information of concern, risk assessments were in place, however, the provider had failed to effectively assess the risks posed to people. The provider had also failed to ensure suitable references had been obtained for those staff members whose DBS contained information about prior cautions or convictions. One of these staff member's references indicated they had been dismissed from a prior employer. However, the provider had not recognised this concern and no further investigations had been completed to ensure the staff member was suitable for work as a member of care staff. One member of staff had references that indicated they had been known by a different name previously. The provider had also not identified this additional name. As a result they had not checked the staff member's criminal history under this name. DBS and reference checks were not being completed in an effective way to ensure staff were suitable to work with people. The provider was not ensuring recruitment processes and pre-employment checks were safe an ensured staff were suitable to work with people using the service.

The provider told us they had made improvements to the recruitment processes since these care staff had been recruited. The provider showed us a staff file for a newly recruited staff member to demonstrate improvements had been made. This staff file also showed that references obtained did not meet the requirements of the provider's recruitment policy. The provider had not recognised recruitment checks were not sufficient and were failing to protect people.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed

At the last inspection we found the provider was not meeting the regulation around providing safe care and treatment. Staff did not understand the risks to people, risk assessments were not in place and accident and incidents were not always recorded. At this inspection we found improvements had been made. People told us they felt care staff understood how to keep them safe. One person told us, "They're very aware of my safety". Another person told us, "They make sure I am safe when using my equipment". A third person told us, "I definitely feel safe with them. They know what they are doing". Staff we spoke with could describe how they supported people in a safe way. For example, how they supported people in a way that reduced the risk of injury to them. Staff could also describe how they recognised potential risks to people such as if they were beginning to develop pressure areas that needed attention. We found the deputy manager had developed risk assessments with the care supervisors that were now in place in people's care files. Staff were aware of these risk assessments and knew how to keep people safe. Risk assessments detailed practical steps that care staff should take to protect people. For example, ensuring a person had certain items in easy reach of their bed to ensure the risk of a fall from bed was reduced. When we visited people in their home we saw some of these actions to keep people safe had been done. We also found staff members had begun to record accidents and incidents and records were now kept in the office. People were protected by a staff team who understood the risks to them and how to keep them safe from potential harm such as injury.

At the last inspection we identified widespread concerns about the time at which people received their care visits. At this inspection we found improvements had been made. Most people told us they had seen these improvements. One person said, "They can be a bit late. It has been a big problem in the past but much better now". A relative told us, "I would say they have improved recently. We had occasions when the carers did not turn up so [my relative] was definitely not safe then. However, this has not happened lately". Most people told us they were very happy with the time they received their care visits. A relative told us, "You can set your watch by them". People told us they had a consistent team of care staff who understood their needs and had the skills need to support them well. One person told us, "I know who is coming all of the time", they told us, "We never get someone we don't know knocking the door". Another person told us, "I have a team of six carers, so I always have the same ones. I receive a print out of who is coming when". However, some people told us they continued to have issues with the timing of their care visits. People and relatives told us they didn't think the rotas were always well organised and sometimes times were incorrectly scheduled. One relative told us their family member received their care visits too early. They told us, "We had the reverse problem when they arrived at 5.45am to wash [my relative]. Far too early!". Another relative told us they raised a concern when care staff had not arrived. A third relative told us their relative had not received a care visit in the weeks prior to the inspection. We confirmed this from records held in the office. Most people received their care visits as scheduled, however, some issues around the timing of care visits had continued.

Staff told us they felt rotas had improved and there were sufficient numbers of staff. One staff member told us, "You never really get phone calls to say can you cover". They told us they knew to report issues to the office if they were running late for care visits. We looked at the systems used to monitor the time at which people received their care visits and saw considerable improvements had been made to the overall timing of care provided. A care supervisor told us spot checks were helping to ensure improvements were made. We also saw the care visits were monitored regularly and checks were made when care visits were particularly late or early. We spoke with the provider who told us they recognised some further improvements were still required.

At the last inspection we found there were inadequate systems in place to ensure people received their medicines as prescribed. At this inspection we found improvements had been made, however further improvements were required. The deputy manager had ensured that the care staff team had records available to them to outline the medicines people received. They had also begun to ensure care staff completed medicines administration records (MAR) to enable them to monitor the administration of medicines. Most people told us they were happy with the support they received with their medicines. A relative told us, "They keep [my relative] safe by giving [them their] medication on time". Some relatives did however raise some concerns about the skills of care staff administering medicines. One relative told us care staff had tried to administer the incorrect medicines however the person noticed this and corrected care staff. Another relative told us care staff had not alerted them to the fact medicines were not available to administer to a person. This resulted in the person not having their required medicines for several days. Staff we spoke with could describe how they safely gave people their medicines and recorded the administration. Staff could describe the steps they would take to report concerns such as refusals of medicines to the office. We saw care plans contained details of the support people required with their medicines and MARs were in place detailing the medicines care staff had given to people. We did however identify that some improvements were still required. For example, managers did not know how to safely dispose of people's medicines and had instructed care staff to flush tablets down the person's toilet. When care staff reported medicines had been found on a person's floor there had not been sufficient consideration on the impact of the missed medicines to the person's health and no action had been taken. We found two examples of where care staff were administering medicines that were not outlined in the person's care plan and a MAR was not in place. The deputy manager told us they would investigate this to ensure the medicines were safe

to administer and were being administered as prescribed. The deputy manager also told us they were developing guidelines to describe to staff how they should administer 'as required' medicines to people. People who had the capacity to make decisions about their care were able to tell care staff when these medicines were needed. However, care staff did not have clear guidance where people may not be able to ask for their own medicines. Improvements had been made to the medicines management systems and most people were receiving their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

At the inspection completed in May 2016 we rated the provider as 'requires improvement' in the key question of 'is the service effective'. At this inspection we found the provider had made improvements to the skills and competency of the staff team. However, we found they were not meeting the regulation around the need for consent.

People told us care staff asked for their consent before providing them with support. Some people told us that staff always explained what they were doing and spoke to them about it. Relatives we spoke with supported this view. Staff we spoke with understood they needed to seek people's consent before providing them with support. One staff member told us, "I tell them everything I'm going to do and ask if it's ok for me to do it". People were enabled to consent to the care they received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At the last inspection the deputy manager provided assurances that decisions made on behalf of people were made in line with the MCA although these decisions had not been recorded. They had provided assurances they would begin to record decisions made on people's behalf. At this inspection we found these decisions were still not being recorded. We found the deputy manager and staff team were not recognising when they were making decisions on people's behalf and how to use the MCA in order to protect their rights.

Care staff had a basic knowledge of the requirements of the MCA however they did not understand how to apply this in their work. They knew to ask supervisors and managers if they had any concerns about people's capacity. However, we found supervisors and managers did not have a sufficient understanding of the requirements of the MCA. We found care staff and supervisors did not understand how to identify if someone may not have the capacity to make a decision about their care. They gave us differing views of who had capacity to make certain decisions. These views also differed to those shared by relatives. Some relatives told us care staff had not recognised concerns about people's care where they lacked capacity. For example when people had refused to eat. We also found staff had not considered the specific support some people may need with their medicines where they showed a reduction in their capacity. We spoke to the deputy manager about some of these examples and they demonstrated decisions had not been made in line with the MCA. We identified several concerns that had not been addressed in line with the MCA. We saw there were no assessments of people's capacity in their care files and decisions made on behalf of people were not being made in line with the Act in their best interests. People's rights were not upheld with the effective application of the MCA.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activites) Regulations 2014 Need for consent.

At the last inspection we found people didn't feel care staff had the skills required to support them

effectively. At this inspection we found people's views around the skills of the care team had improved. People told us they could see the improvements within the staff team. One person told us, "The carers are all good, we are happy with them. We had problems in the past but they are sorted now". A relative told us, "I think they are getting there with their training". Most people told us they were very happy with their care staff. A person said, "I think they are very good. I have an excellent team". Another person said, "They are all really good. Absolutely satisfied with them all. I find them invaluable". Some people and their relatives told us while they felt some care staff were excellent, they felt others did not have the skills needed. A relative told us, "The other girls are great. It's just [two named care staff]". Another relative said, "Sometimes [my relative] feels unstable when they support [them] at night". A third relative said, "We had a problem with one carer and she does not come now". A further relative told us they didn't feel all of the care staff had been sufficiently trained. The provider and deputy manager confirmed they were reviewing the performance of a number of care staff members. However, we found the care supervisors we were told were working with the care staff to improve their performance were not always aware of the performance concerns of staff. Concerns about staff performance had been identified, however there was no clear plans outlining how improvements would be made. Spot checks completed did not identify areas of improvement required. People were mostly happy with their care staff, however, where staff skills required improvements action was not always taken.

Staff told us they had sufficient support and training available to them. One staff member told us, "I know I can come in (to the office)", they told us, "[Supervisors and managers] are always here for me to talk to". A care supervisor said, "I've had quite a bit of training from [the provider] and [the deputy manager]". Staff and supervisors told us training provided was much improved since our last inspection. They told us how an online training system had been introduced to compliment the practical training they received. Training records we looked at confirmed that further training had been provided since our last inspection on the areas that we identified as a concern, such as moving and handling and managing medicines. We did see however, the provider was not ensuring staff members were completing training that was important to their role. For example, we found the provider, care supervisors and care staff did not have sufficient knowledge in how to report safeguarding concerns. The provider had made improvements to the training provided however further improvements were still needed to ensure staff had the skills needed to keep people safe and provide effective care.

Most people we spoke to told us they managed their own day to day health needs, including arranging healthcare appointments, or their relatives provided support. Some relatives felt care staff were not always vigilant and did not always recognise and report potential areas where people's health could be at risk. For example, if their medicines were not available to them or if they had refused their meals. We saw an example where one person we visited had not taken their medicines and advice had not been sought. We did see however a care supervisor seeking medical support for one person as care staff had become concerned about their health. People did receive support to maintain their day to day health needs. However this was not consistent across the service as staff did not always recognise the need to report concerns and seek additional support for people.

People told us they were happy with the support they received with their food and drink. One person told us, "Yes they get breakfast for me, prepare lunch and make sure I have a drink". Staff understood people's dietary requirements and prepared appropriate meals for them. A relative told us, "They do prepare meals for her which is important as she is diabetic". We saw care plans contained information about people's food and drink requirements. We did find that people who lacked capacity to make decisions may not always receive the additional support they required with their food and drink. For example, where they may refuse meals.

Requires Improvement

Is the service caring?

Our findings

At the last inspection completed in May 2016 we rated the provider as 'requires improvement' for the key question of 'is the service caring'. At this inspection we the provider had made improvements however further improvement was still needed.

People told us most care staff were kind and caring. One person told us, "The carers are very kind. I am very happy with them". Another person told us, "They are respectful when they talk to me and caring [care staff]". Relatives also told us they felt staff were kind and caring. A relative said, "They are very caring and kind hearted". Another relative said, "I would say staff are very caring and respectful". One relative told us how care staff paid attention to detail and made their family member feel valued and important. They told us, "He had his hair cut and they notice that". Some people and their relatives did said that while they felt most care staff were kind and caring this was not consistent and there were still issues. One person told us care staff did not engage and talk with them. They told us, "They just come in clean me then go in [the other room]". A relative told us, "Whenever we go in they're [care staff] normally sitting [doing nothing]", they told us, "It's like they want the money but not the job". Another relative told us they felt care staff were disrespectful to their family member and did not respect their property. People felt most care staff were kind and caring but this was not consistent across the whole staff team.

People told us communication with the office and management team had improved, although we were told by some that improvements were still needed. Some relatives told us they had raised concerns on behalf of their family member and these had not been responded to in a caring way. They did not feel the provider ensured they were heard and they communicated with effectively. We did however see some actions taken by the provider demonstrated a caring approach. For example, they had arranged for people to have a new winter blanket to use during the winter months.

We found the provider did not always ensure people had the support they needed to answer questions and make decisions about their care. We were told by staff and relatives that some people lacked capacity to make certain decisions about their care. However we found this had not always been recognised and when care plans were developed and feedback about the service obtained. Appropriate support had not always been put into place to enable people to effectively communicate their views and decisions about their care.

People highlighted some concerns to us about the communication skills of some care staff. A person told us, "I am quite deaf and sometimes I can't understand [staff member name]". Several relatives told us they had experienced issues with care staff not using the language spoken and understood by the person using the service. We saw care staff had been spoken to about this issue. It was confirmed by the provider that care staff could speak the language used by people but chose not to. The provider recognised this issue and told us further work was required to resolve some communication issues.

We were told about some good practice used by care staff around communication and offering people choices. A relative told us, "[My relative] is partially sighted and quite deaf. Carers do talk to [them] to let [them] k now what they are doing". Another relative told us how care staff offered choices around what the

person wanted to do. They told us, "They ask if [my relative] wants to get up and dressed". Staff could describe how they used effective communication to help people feel at ease and also to make choices. One member of care staff could describe how they helped one person orientate themselves with the date and time by putting on a news channel. They found the clock in the corner helped them to remember what time of the day it was and eased their confusion and distress. This staff member was able to describe how they supported the person to make choices. They told us the person was not able to remember the names of certain food but could make choices by looking at the items and having visual reminders. People were supported by care team who had good communication skills and supported them to make choices, although this was not consistent across the whole staff team.

People told us care staff protected and promoted their privacy and dignity. One person told us, "[Care staff] make sure I'm not left uncovered". Another person told us, "They let me wash as much as possible and then help when I need it. People also told that they felt the consistency of the care staff visiting them had improved. People told us having consistent staff they knew helped them feel more comfortable and made their care more dignified. Staff were able to describe how they would support people in a dignified way. One staff member said, "You wouldn't open a door while someone was on the bed having their pad changed".

People also told us they felt care staff helped them to maintain their independence. A relative told us, "This service keeps [my relative] in [their] own home, which is what [my relative] wants". Staff could describe how they promoted people's independence. One staff member told us, "We encourage them to eat and drink themselves, take their own medicines and make their own choices." Another staff member told us, "I encourage them to do as much for themselves as possible." They gave an example of one person who was cared for in bed. They told us how they gave the person a bowl to wash themselves in bed and provided support when the person requested it. Staff supported people to maintain their independence.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection completed in May 2016 we rated the provider as 'inadequate' for the key question 'is the service responsive'. We also found they were not meeting the regulation about providing person-centred care and responding to complaints. At this inspection we found improvements had been made but further improvements were still needed. We found the provider was now meeting the regulations around providing person-centred care but they were still not meeting the regulation around responding to complaints.

At the previous inspection we received numerous concerns from people and their relatives about the way the provider responded to complaints. At this inspection we found improvements had been made and some people gave us positive feedback about how the provider had responded to their concerns. One person told us, "I did make a complaint and it was resolved ok". A relative said, "We did have a complaint and they sorted it out straight away". However, some people and their relatives told us further improvements were needed. Several relatives told us they were not satisfied with the reponse they had received to complaints raised. One relative told us about a complaint they'd raised and said, "I tried to speak with the owner because I was so annoyed. Apparently, it was written up but I have not received a copy". Another relative told us they had not received a call back following a complaint they had raised. A third relative told us they did not feel the provider was very good at resolving concerns. During the last inspection we found the provider was not keeping a written record of complaints. At this inspection we found the provider had begun to keep records. We found however the provider was not responding to complaints in line with their complaints policy. While the provider demonstrated they had spoken to care staff about concerns raised they had not always provided an appropriate response to the person or relative in line with their policies. The provider was not consistently responding to complaints in an appropriate manner in line with their policy and procedures.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Responding to complaints

At the prior inspection we found people were not always receiving care and support that met their needs and preferences. People told us they did not receive their care visits at the time they needed or wanted them. People were not always aware of their care plan and the care plans did not accurately reflect people's needs. At this inspection we found the provider had made improvements and was now meeting the regulation around providing person centred care. However, some further improvement was still needed.

Most people told us care staff knew them well. They told us they received care and support that met their needs and preferences and they were aware of their care plan. One person told us, "Yes I think they know me well. They do everything I need without having to ask". Another person said, "Yes I have a care plan and they do everything I need." A relative told us, "[My relative] has a care plan and carers do everything in it. They send it to us to see if we agree with it". Another relative said, "I would say the present carers do know [my relative] well. It has been a problem in the past but much better now". We saw one person's care plan outlined they should be left with their emergency pendant on and with three bottles of juice next to their bed and we saw this had been done. We found the provider had made significant improvements to the time

at which people received their care visits. One of the care supervisors told us they are focusing on people's involvement in their own care plan. They told us how they involve people who may not be able to communicate easily. The care supervisor explained how one person is unable to speak and uses the movement of their head to indicate if they agree or disagree. They told how they used this communication to enable the person to make decisions about their care plan. We did however receive feedback from people and their relatives that indicated further improvement was still needed. For example; a relative told us that inconsistent call times in the morning sometimes prevented a person from getting the care they needed. They told us when care staff arrived late the person had got up and dressed themselves and therefore did not receive a shower.Daily records we looked at for the person confirmed what we were told. We received feedback from other relatives where they felt improvements could be made in planning their relatives care. We found relatives felt these people did not always have capacity to make decisions about their own care and the person had not received appropriate support to develop their care plan. Some relatives told us there were still some issues with certain care staff understanding the needs of people. They told us their regular care staff understood people well but when other care staff provided support they did not always meet their needs. A relative said, "[My relative] has highly specific needs and I think they need to send the same staff as often as possible. Ones who know [their] care needs well". The provider was ensuring some people received care and support that met their needs however this was not always consistent across the service.

People and their relatives gave positive feedback about the new care supervisors and and most told us they received regular reviews of their care. People told us that care supervisors were making regular calls to them to ask if there had been any changes in their care needs. We saw these calls being made to people during the inspection. One relative told us the care supervisors had helped changed the time of the person's care visits when the person needed to attend an event. They told us their request had been dealt with promptly. They also told us the care supervisors had provided additional support to contact social services when the person's care needs had changed. Some relatives told us they did not feel they were sufficiently involved with their family member's care reviews when they lacked capacity to make decisions about their care. One relative told us, "I've had one review that I requested". We saw this person's care plan had recently been reviewed and signed by the person. We found the provider had not considered the concerns raised by the family about this person's capacity and appropriate support had not been in place for the review of their care. The provider was ensuring people's care was reviewed regularly but they were not considering the support people required if they lacked capacity to make decisions about their care provision.

Inadequate

Is the service well-led?

Our findings

At the last inspection completed in May 2016 we found the provider was not meeting the regulations regarding the effective management of the service, submitting statutory notifications to CQC and displaying their CQC inspection rating. A statutory notification is a notice informing CQC of significant events such as a serious injury, safeguarding concern or death and is required by law. We found at this inspection the provider had made some improvements. They were now meeting the requirement to display their CQC inspection rating. However, they were still not meeting the regulations around effectively managing the service and submitting statutory notifications.

We found the provider continued to fail to submit the required statutory notifications regarding significant incidents that had occured. For example, we identified an allegation of potential abuse the provider had failed to notify us about.

This was a breach of Regulation 18 of the Care Quality Commission (Registraton) Regulations 2009 Notification of other incidents

The provider had failed to ensure they had safe systems in place to ensure all members of the staff and management team, including themselves, understood how to recognise and report abuse. They had not ensured they understood their legal responsibilities and that potential risks to people were sufficiently understood. We found their safeguarding policy that staff should not conduct internal investigations prior to reporting to the local authority. We found internal policies and procedures were not understood by staff and often contradicated themselves. For example, the safeguarding policy did not reflect current legislation, such as the Care Act 2014. It also provided staff with conflicting information to the whistleblowing policy which outlined internal investigations would be completed prior to contacting organisations such as the police. The provider had not ensured people were sufficiently protected by effective systems to safeguard them from potential abuse.

At the last inspection we found there were no recorded audits on the quality of care delivered to people and there were insufficient records relating to incidents and complaints. At this inspection we found the provider had begun to keep records of incidents and complaints. They had also begun to complete checks on documents such as accidents, complaints and feedback surveys. However, we found quality assurance checks were still not effective at identifying areas of concern or required improvements. For example, checks completed on daily care records did not identify that two people were having creams administered by care staff that the provider was not aware of. The provider was not able to confirm if these creams should be administered. These medicines were not outlined in people's care plans and managers had not ensure these people's needs around the medicines were fully understood and met. They had also not identified that people may not always receive the care they needed. For example, a person was not always receiving the personal care they required due to inconsistent call times. We did however find significant improvements had been made in the times at which people received their care visits due to the monitoring completed by the provider. The provider was not ensuring quality checks were effective in identifying concerns with the delivery of people's care.

The provider was not recognising when the service was not meeting the required standards and further improvements were still required. The action plans given to us by the provider stated that several areas of concern within the service had been resolved and the required improvements had been made. We found this was not the case. For example, the provider stated they were now reporting all safeguarding issues to the local safeguarding authority. We found the provider was not reporting safeguarding concerns without delay and had put people at risk as a result. The provider stated all statutory notifications were being submitted to CQC, although we found this was not the case. The provider also stated in their action plan and management meeting minutes they were now compliant with the requirements of the MCA, although we found this was not the case.

We saw records of complaints were now being kept, however, they were not being audited for trends in order to identify lessons learned and overall areas for improvement. We found a full investigation was not always completed and a written response provided to the person raising the complaint in line with the providers complaints policy. Where we saw written responses were not provided people's relatives told us they had not received a response from the provider. We shared a complaint with the provider prior to the inspection. There had been concerns about one person's care and we asked the provider to provide an appropriate response. We found the provider had failed to provide a response and had not addressed the areas of concern with staff in order to prevent similar concerns arising in the future. The provider also gave assurances that all staff members had now had robust recruitment checks completed. They told us any concerns about recruitment procedures had been addressed and staff were now recruited safely. The provider had failed to identify that recruitment processes were still not safe and further improvements were still required.

We found the provider did not always ensure improvements required in the skills and knowledge of the staff and management team were understood and addressed in order to ensure people received a good standard of care. For example, supervisors did not fully understand how to protect people's rights where they may lack capacity to make certain decisions about their care or to provide consent. Care supervisors were also not aware of the performance concerns regarding specific care staff members. We saw the provider had taken disciplinary action where some performance concerns were identified. However, we found this was not always the case. We found the provider had simply asked some care staff to 'take more care' when certain concerns were identified. They also told us they did not want to progress their disciplinary policy as they wanted to give some staff members 'a chance'. This was despite people and relatives raising concerns about the performance of some care staff. The provider was not ensuring sufficient improvement was made in the performance of some staff members to ensure people's experiences of the care they received was improved.

Most people told us they were provided with opportunities to give feedback on the service they received. They told us care supervisors were making regular telephone calls to them to ask about their experiences. Some complaints had been identifed through these calls and we saw action had been taken to resolve some of these concerns. One of the care supervisors told us, "We're trying to have as much contact as we can now with [people]". They told us they were working to make people more confident about raising concerns with the service. We saw the provider was sending out surveys to people to obtain their views. However, some people we spoke with told us they had not recived a survey. We also found as the provider had not identified where people may have a lack of capacity to complete these questionnaires. As a result people were not always given the appropriate support to provide feedback. Some survey results were not reflective of complaints received about the persons care. The provider did not always consider how to obtain effective feedback in a format that was accessible to everyone who used the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 Good governance

Feedback from people and their relatives about the provider and the management team had improved since the last inspection. One relative told us, "I must say they have been trying lately and the service is much improved". Most people said they knew who the provider and deputy manager were. One person told us, "I have spoken to [the provider]. He has helped in the past". However, further improvement was still needed. Some people and relatives did say they weren't sure who managed the service. One person said, "I have never had contact with the manager". A relative said, "I don't know the manager". Another relative told us, "I think they have greatly improved over the past few months. They are trying. The communication between carers and office could be improved so that everyone knows what is happening". People gave us positive feedback about the care supervisors and told us they had listened to them and had helped with their care.

Staff also gave positive feedback about the management and office staff. One staff member said managers were, "Great! I've no complaints whatsoever". They told us, "If ever I need anything they will help me". Another staff member said, "If I have a problem they're always here for me". We saw regular meetings were now being held with staff members to address some areas of concern within the service. For example, we saw minutes of meetings that showed areas of improvement needed had been discussed such as reporting changes to care plans, how to record the administration of people's medicines and the time at which people received their calls. People were cared for by a staff team who felt supported in their role.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not ensuring statutory notifications were submitted to CQC as required by law.

The enforcement action we took:

We have taken action to cancel the registration of this provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not protected through the effective application of the Mental Capacity Act 2005.

The enforcement action we took:

We have taken action to cancel the registration of this provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure allegations of potential abuse were managed safely and people were protected from further abuse.

The enforcement action we took:

We have taken action to cancel the registration of this provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not ensure people's complaints were always recognised and responded to appropriately.

The enforcement action we took:

We have taken action to cancel the registration of this provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected by quality assurance systems that identified the areas of improvement required in the service. The provider did not recognise when the service was not meeting the required standards.

The enforcement action we took:

We have taken action to cancel the registration of this provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected as the provider was not ensuring care staff were recruited safely and were appropriate for their role.

The enforcement action we took:

We have taken action to cancel the registration of this provider and registered manager.